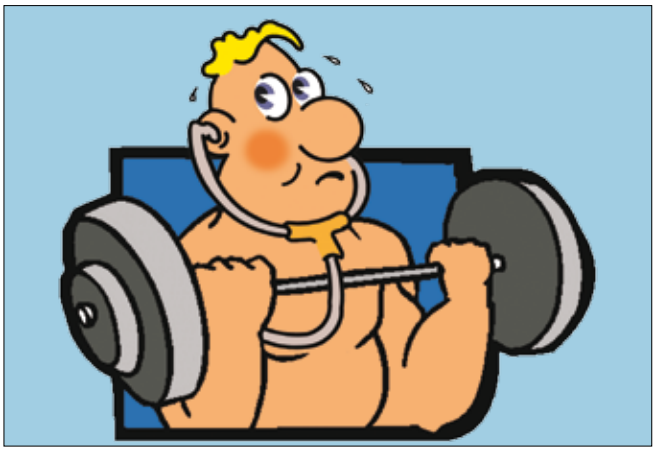
network
NETWORK 25 MARCH 2009

Anabolic steroids



Key points for practitioners

- **Recognise the potential for steroid use in patients — particularly those who present with mesomorphic or hypermesomorphic body types.**
- **Always approach the issue in a non-judgemental way and listen to the patient's concerns.**
- **Recognise that there are diverse drivers of steroid use and look at motivations for use — can their goal be achieved without steroids?**
- **If an individual is intent on using steroids, then basic harm reduction advice should be given.**

Harm reduction advice for steroid users

- Always use sterile injecting equipment. Never share.
- Use the smallest dose of steroids (do not adopt other users' regimes).
- Limit the length of "on cycles".
- Be aware of counterfeit drugs.
- Know how to inject safely.
- Spend adequate time on training, nutrition and sleep.
- Know the dangers of recreational drug use.
- Be aware of side effects. At the first sign of them, discontinue use and seek medical advice.
- If you need to take drugs to treat the side effects of your steroid use, it means your dose of steroids is too high.
- Inform your GP (and any other health practitioner) of your anabolic steroid use and take advantage of any health monitoring that is available.
- Just because you have read something about steroid use on the internet or from a magazine (or heard it from another user) doesn't necessarily mean it's true!

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In this issue

We hope you enjoy this edition.

Editor

Don't forget to become a free member and receive regular clinical and policy updates - the newsletter can also be emailed to you – all for free www.smmgp.org.uk/membership

Editorial

SMMGP are delighted to announce that we have a new Project Manager, Elsa Browne who took up post in February. Elsa has worked in a variety of roles in the drugs field and the experience and skills she will bring to SMMGP are going to help us develop the project to new heights!

This edition of Network highlights up-and-coming developments in the drug field. **Siobhan Fahey's** article on dried blood spot testing provides readers with an up-to-date way of making blood borne virus screening and immunisation services more accessible - and April Wareham reminds us of how important it is that drug users receive essential medications when they are in custody. **Jim McVeigh and Michael Evans-Brown** provide insight into how to work with steroid users, an area which can leave many of us feeling out of our depth (and don't forget to read the full article on our website www.smmgp.org.uk).

We are busy preparing for two conferences in the coming months. The RCGP 14th National Conference: Working with Drug & Alcohol Users in Primary Care - ***Family Medicine: From Cradle to Grave*** is on 7th and 8th May 2009 at the ACC Liverpool, and promises to offer both a 'back to basics' approach, and also to look at new developments in primary care drug treatment services. We are also paying special attention to alcohol services at this year's conference - so don't miss it!

The speed of change in drug treatment can sometimes be overwhelming and we have noticed that services are increasingly being reconfigured and re-tendered in order to meet local need and the changes in policy. In this process it is increasingly important that all services, service users and commissioners are able to work together in partnership in order to provide the best possible services for the future. We are therefore excited to announce that *SMMGP's 4th National Primary Care Development Conference* has the theme of ***Partnerships in progress: working together.*** This event takes place on Friday 9th October 2009 at the Brooklands Hotel, Barnsley and is a must for primary care clinicians and also for secondary care providers, service users and commissioners involved in working with primary care drug treatment services. For more information visit our website www.smmgp.org

Enjoy this issue!

Kate Halliday

Network Editor

Siobhan Fahey's **article highlights the potential benefits of dried blood spot testing for blood borne viruses, and the way in which the practice has been rolled out in Greater Manchester across drug services. This development is improving access to services and is increasing the uptake of testing for hepatitis C and HIV in the area. Ed.**

The roll out of dried blood spot testing in Greater Manchester

The Greater Manchester Hepatitis C strategy (GM HCV Strategy) has promoted the development and use of dried blood spot testing. A programme of training for drug workers has been developed and is at present being rolled out in the area. The GM HCV Strategy aims to increase by 1400 the number of tests performed across Greater Manchester, and to ensure that the test is available to all drug users accessing drug services. The test should be easily accessible from a drug worker or through needle exchange services. It is an innovation that may be of interest to primary care physicians who wish to increase the testing of blood borne viruses (BBVs) amongst clients with poor venous access.

The purpose of the GM HCV Strategy is to develop a collaborative, coordinated approach to hepatitis C across Greater Manchester in line with national and local guidance and needs assessments. It aims to develop local services to meet the increasing need and demand within the population. The strategy has a number of ongoing projects: service redevelopment which includes care pathway redesign; communication using social marketing principles; increasing testing across all high risk groups; research, including a comprehensive health care needs assessment; workforce development including training needs mapping; and a BBV prevention project. In 2007 the Association of Greater Manchester PCTs agreed recurrent funding for the project.

> ***"Perhaps the technique's greatest advantage for testing for hepatitis C is its use in people with poor venous access."***

The process of dried blood spot testing involves the collection of peripheral blood by piercing the skin of either a finger or a heel with a lancet. The blood is blotted onto high quality filter paper. The blood spot is then allowed to air dry. Samples can then be tested immediately, stored at ambient temperatures, or frozen. The concept that capillary whole blood can be used to test for diseases was introduced by Guthrie and Susie in 1963, so the technology is well tested[1].

There are many advantages of dried blood spot testing. It is simple to perform and does not require specialist training. This means that BBV testing can be carried out by health care assistants and drug workers who do not have nurse or phlebotomy training. The technique does not involve the risks associated with the use and disposal of needles and syringes,

1 Parker S and Cubitt W (1999) The use of dried blood spot samples in epidemiological studies Journal of Clinical Pathology 52 633-639

therefore dried blood spot testing represents a low infections hazard in diseases such as hepatitis C which are known to be present in serum, as they lose their infectivity owing to disruption of their envelope on drying. Risks associated with shipping are minimal as dried blood spots cannot leak or be broken in transit, and do not require expensive transport medium. Perhaps the technique's greatest advantage for testing for hepatitis C is its use in people with poor venous access. As the majority of people with hepatitis C in the UK have a history of intravenous drug use, poor venous access is often a problem meaning that people at risk may not be tested[1], even though they wish to be, due to difficulties in taking blood.

The GM HCV Strategy has funded the Manchester virology laboratory to develop dried blood spot testing locally. The Manchester laboratory worked with the original Guthrie technology, but has developed a number of innovations which make the use of the technology simpler and quicker. In other dried blood spot testing techniques the blood spots are punched out. This carries a risk of cross contamination, which can only be removed by decontaminating the punching tool, which involves extra costs. In Manchester the scientists developed a blotting paper kit which allows the blood specimens to be ripped off, preventing the contamination risk. The tests were validated on micro particle based automated instrumentation, which allows a higher sensitivisation and a higher throughput. This allows more tests to be carried out more quickly and easily, and allows the tests to be carried out during the normal run of lab tests. It also means that confirmation, polymerase chain reaction (PCR), genotype, HbsAg (surface antigen of the hepatitis-B-Virus), HbcAb (hepatitis B core antibody) and HIV tests can be carried out on the same sample. The laboratory worked closely with the Health Protection Agency to achieve competitive pricing with the dried blood spot kits and the associated laboratory costs. When the tests were validated it was found that HCV antibody detection sensitivity and specificity was 100%, and the HCV RNA had a sensitivity of 96% and a specificity of 100%. At present the Manchester virology laboratory is the only service in England and Wales which has validated the technique. The tests are available from the laboratory manager Dave Ellis dave.ellis@cmmc.nhs.uk

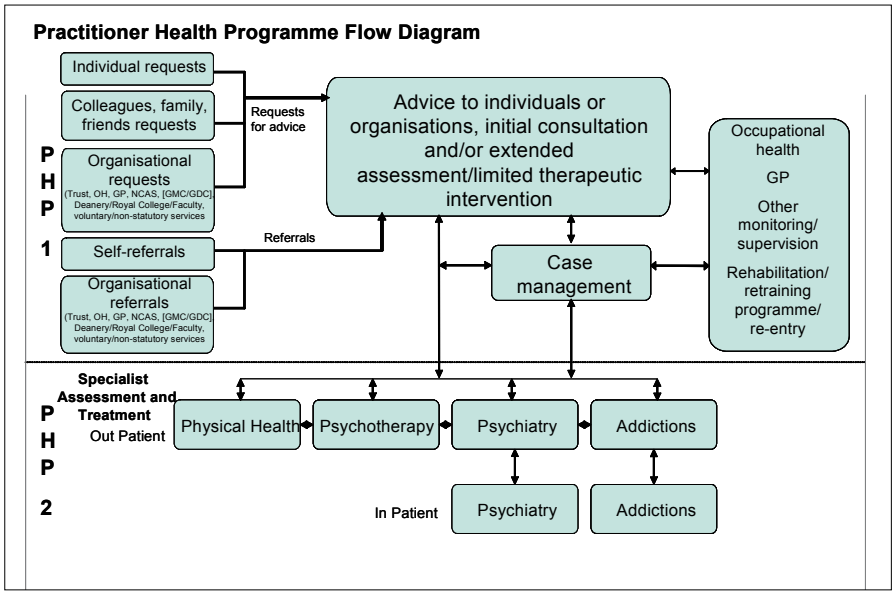
Once the tests and kits were fully validated the GM HCV Strategy invested in promoting the use of the technique within substance misuse agencies across Greater Manchester. The

Strategy commissioned a local mental health agency to develop a 2-day training programme for drug workers. The programme includes increasing knowledge about hepatitis C, harm reduction techniques, the pre- and post-test discussion and the communicating bad news. The training is mapped to Drug and Alcohol National Occupational Standards (DANOS) and the Knowledge and Skills Framework (KSF). As part of the training each participant receives a pre-training pack, which includes a reflective diary. The drug worker is supervised by the service's harm reduction/BBV nurse regarding their skills at carrying out the test after the training. The training was piloted prior to the service being rolled out, and the training was evaluated by Manchester University. Of the piloted group of drug workers, 22% had no formal qualifications, and 72% had received some hepatitis C training in the past. However none achieved 100% on the simple pre-training quiz. After the training there was a significant increase in knowledge about hepatitis C and an increase in confidence about carrying out a dried blood spot test. Though a focus group conducted with the participants revealed concerns regarding the time that performing the test would take, there was enthusiasm for carrying out the tests. The group will be reassessed 6 months after the training to monitor knowledge retention.

So far, two areas have received training, and the testing started two months ago. In the process of the service being rolled out across Greater Manchester, as each area receives training the agency is provided with dried blood spot testing kits and the hepatitis C related laboratory costs. So far 90 tests have been performed, with 43% being antibody positive.

The total cost of the dried blood spot test development and rollout has been £125 000 across 10 PCTs. This rollout will improve access to hepatitis C testing amongst drug users in Greater Manchester and ensure the GM HCV Strategy achieves its target of testing an additional 1400 people.

Siobhan Fahey, Programme Manager of the Greater Manchester Hepatitis C Strategy siobhan.fahey@hmrpct.nhs.uk



Clare Gerada **and** ***Jane Haywood*** **outline an important new London-based service for doctors and dentists experiencing mental and/or physical health problems, and substance misuse problems. We feel that this is a valuable new service and hope that the Practitioner Health Project offers a model for other areas to take forward. Ed.**

Caring for the carers: a new service for doctors and dentists

Introduction

For decades now research has shown that, compared to a matched population, doctors have increased rates of mental health problems. Doctors are reported to have high rates of work related stress, anxiety, depression, somatic and social dysfunction[1] and higher levels of fatigue than the general population[2]. Depression and substance misuse are thought to be contributory to the increased rates of suicide found in doctors[3]. Around 7% of doctors have drug or alcohol problems across their lifetime[4]. Evidence suggests that doctors who misuse drugs also commonly misuse alcohol and prescription medicines, such as benzodiazepines, often interchanging substances on availability.

> ***"Depression and substance misuse are thought to be contributory to the increased rates of suicide found in doctors. Around 7% of doctors have drug or alcohol problems across their lifetime"***

There are many and complex reasons why doctors appear so vulnerable to mental health and substance misuse problems. These reasons can be thought of as being due to the individual, (perfectionist, recruited for commitment to public service, ability to attend to detail), the job (long hours, frequent change of location/teams/role, isolated working patterns, dealing with high levels of physical and emotional distress) and cultural factors (guilt, not wanting to "let your colleagues down", feeling that sickness in oneself is a failure and something to be ashamed of). Some of the qualities that contribute to good doctoring (such as conscientiousness, attention to detail, commitment to caring, and stoicism) also, paradoxically, contribute to the factors that predict vulnerability to mental health problems and act as barriers to help-seeking behaviour. Doctors, like the rest of the population, are affected by stigmatising images of mental illness and its treatment[5].

The Practitioner Health Programme

The Practitioner Health Programme (PHP), headed by Dr Clare Gerada, is a two-year prototype service based in London. This service has been funded by the Department of Health and commissioned by the London Strategic Health Authority and National Clinical Assessment Service (NCAS). PHP is a free, primary care, low-threshold, stepped-care service that can be accessed via the web: www.php.nhs.uk, confidential e-mail and a telephone help line. The service is for doctors and dentists living or working within the London area who have mental health and/or physical health concerns that might be affecting their work, or addiction problems of any severity. The service is complementary to existing National Health Service (NHS) and other services, rather than a replacement of them. Potential practitioner patients, their family members or concerned colleagues can contact PHP anonymously to discuss concerns and prospective referrals for assessment.

Unlike general practice, PHP has the resources to provide a 'Super Service' for doctors and dentists experiencing illness and/or alcohol/drug use that affect their work. One of the main benefits is time. The initial assessment can take around 2 hours. We are mindful that many practitioners have not had the benefit of healthcare and often on their first presentation the need to 'off load' is immense. Practitioner patients can experience the 'GP approach' toward assessment and therapeutic engagement.

As part of the stepped care model, practitioner patients requiring specialist input or an inpatient setting will continue to be monitored by the primary care led team (PHP1) but will have access to a range of services (PHP2). These consist of a number of preferred specialist providers. These providers include: Capio-Nightingale, Tavistock and Portman NHS Foundation Trust and South London and Maudsley NHS Foundation Trust. Clouds House in Wiltshire can provide additional residential provision. In exceptional cases, referrals can be made to other providers. PHP2, like PHP1 is provided free to the practitioner

1 Baldwin, P., Dodd, M. & Wrate, R. (1997) Young doctors' health: how do working conditions affect attitudes, health and performance? Social Science and Medicine, 45, 35–40.

2 Hardy, G. E, Shapiro, D. & Borrill, C. (1997) Fatigue in the workforce of national health trusts: levels of symptomatology and links with minor psychiatric disorder, demographic, occupational and work factors. Journal of Psychosomatic Research, 43, 83–92.

3 Hawton, K., Clements, A., Sakarovitch, C., et al (2001) Suicide in doctors. Journal of Epidemiology and Community Health, 55, 296–300.

4 British Medical Association. The misuse of alcohol and other drugs by doctors. London: British Medical Association, 1998

5 Mukherjee, R., Fialho, A., Wijetunge, A., et al (2002) The stigmatisation of psychiatric illness: the attitudes of medical students and doctors in a London teaching hospital. Psychiatric Bulletin, 26, 178–181.

patient and will operate with the same level of confidentiality, access and quality as with PHP1.

Confidentiality

A major barrier to health professionals seeking help are concerns regarding confidentiality, in particular whether having disclosed mental health or addiction concerns will lead to a referral to the GMC. The PHP service guarantees the same level of confidentiality as for any other non-health care professional patient. An agreement has been drawn up with the General Medical Council (GMC) confirming that the practitioner patient can be treated in an entirely confidential manner unless there are serious risks to patient safety. The GMC has also agreed that PHP can have informal, confidential discussions about any doctor where PHP have concerns about patient safety. Only in exceptional circumstances will information be disclosed and always with the knowledge of the practitioner patient.

The Future

The PHP service has now been in operation since early October 2008. Even before completion of the developmental stage referrals have been arriving, confirming the well-known maxim "if you build it they will come". Doctors and dentists have self referred, been referred by colleagues, spouses, friends, employers, medical directors, the GMC, NCAS, NHS specialists and via self-help support services. The distress and isolation that sick health professionals have to endure underlines the need for such a service which, hopefully, if proved to be successful will be expanded to cover the whole country.

For further information, please visit our web site: www.php.nhs.uk

Dr Clare Gerada and **Jane Haywood, PHP**

Gordon Morse **discusses the power of the doctor-patient relationship and how it can be influenced as much by personal prejudice and culture as it can be by evidence and guidelines.** **Ed.**

Prejudice and dogma in treatment

For all we know, we could be in daily contact with paedophiles, terrorists and racists: they may be on the supermarket check-out, speak to us from a call centre, or pass us by on the pavement. If we were to find out their clandestine beliefs it may not matter to us that much because our relationship with them was not important. But it certainly would matter to us if they happened to be our Member of Parliament, a high court judge or the teacher of our children. In other words, the more power that someone holds over us, the more important becomes that individual's beliefs to us. Indeed you might even say that the more important the relationship, the more important it is that that person has similar beliefs to us, and if not, then at least has no opposing beliefs.

> ***"In recent years GPs have been condemned for prescribing heroin to heroin users – but today diamorphine prescribing is being piloted again as a legitimate treatment intervention. It seems that much of what we believe is subject to fashion and what we are told to believe"***

And so what of the doctor-patient relationship? This is one of the most powerful relationships that almost every individual is subject to. Some doctors have been terrorists (famously Che Guevara for one), paedophiles and racists – but fortunately very few. A few more hold religious and moral beliefs that can cut across the expectations and needs of the patient. But in the main I am sure that most doctors subscribe to the General Medical Council's Code of Good Medical Practice (2006) and "listen to patients and respond to their concerns and preferences, and respect their right to reach decisions with you about their treatment and care" without allowing their own prejudices to conflict.

But I am *not* so sure that this concordance is as widespread when it comes to doctors' relationships with drug using patients. There may not be huge numbers of radicals or deviants amongst us (some may disagree), but there certainly are some very deeply held prejudices; the obvious example is the chronic professional rivalry between the abstinence and harm reduction lobbies. Up until Nyswander and Dole, the mainstream wisdom was that abstinence was the only treatment for addiction. Since then, and bolstered by numerous scientific papers, medics have espoused a harm reduction approach. That was until recently, when senior police officials and some prominent MPs have attempted to discredit harm reduction in favour of a return to an abstinence approach. The notion that either philosophy should apply to all patients all of the time is preposterous, yet some of the arguments aired in public certainly seem to give that opinion. Similarly the Advisory Committee on the Misuse of Drugs report Hidden Harm[1] was influential in persuading professionals that it is the quality of parenting that dictates whether or not a child should be placed in care, not simply the drug using status of the parent – but the tragic events in Haringey recently will surely shift that pragmatism: fear and dogma will return, families will be torn up and lives will be forever changed. In recent years GPs have been condemned for prescribing heroin to heroin users – but today diamorphine prescribing is being piloted again as a legitimate treatment intervention. It seems that much of what we believe is subject to fashion and what we are told to believe.

So even though most of us are not holding obviously extreme views, our actions are strongly influenced by beliefs, prejudices and popular dogma; scientific evidence itself, the mantra that we are all supposed to believe in, is temporal – Albert Einstein re-wrote previously held Laws of Physics, but was intuitive enough to know that some of his new Laws would one day be found wanting – as indeed have some been.

So what are we to believe? The world of substance misuse is full of uncertainty, risk and grey areas. Patients have widely differing needs, experiences and agendas, and in many cases are more expert about their needs than doctors are. How do we exercise this powerful relationship that we have with them in a meaningful and helpful way? By listening to their beliefs and understanding them - and by being aware of our own prejudices and by constantly challenging them.

Gordon Morse Clinical Lead of the Somerset Integrated Drug and Alcohol Service

RCGP Drug Training Lead South West

1 Advisory Council on the Misuse of drugs (2003) Hidden Harm: responding to the needs of the children of drug users

Richie Moore **takes us through the history of advocacy in the drug treatment field and explains why it is important that this service is available to people receiving treatment in all drug services, including primary care. Ed.**

The devil's advocate? Advocacy for patients in primary care

"Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice" Action for Advocacy[1]

What do advocates do?

Many drug users internalise media and social messages and after a while feel they only deserve a second-class service. If you add to this the fact that some users come with a poor self-image and a poverty of expectation before they even develop a drug problem, then it's easy to see how users may find it difficult to get heard, or even to believe they have a right to a voice in the first place. It's an advocate's job to both encourage service users to find their voice and to work to get their opinions and needs recognised and their rights upheld.

There are some historical examples of drug users striving to get their voices heard. The Committee of Concerned Methadone Patients and Friends met in 1973 in New York to explore methadone advocacy. They managed to bring an effective class action suit against the New York City transit authority for barring methadone patients from employment. They went on to win another suit against a clinic regarding its methadone formulation, which was causing ill health amongst patients. Their existence paved the way for the National Association of Methadone Advocates in America, still active today. In the late 1970's in Rotterdam the Junkie Bond was formed to challenge poor treatment and media bias towards drug users. Faced with an outbreak of hepatitis B, they helped to pilot the first needle exchange.

Advocacy for service users in drug treatment in the UK

In 1998 Bill Nelles founded the Methadone Alliance[2], along with a group of drug users and professionals, to campaign to improve quality and availability of drug treatment in the UK. Now called The Alliance, they provide a network of regional advocates for people experiencing problems with their treatment.

Across the UK many service user-led organisations are providing advocacy for drug using clients. Examples include the Oxford User Team, MORPH in Southampton, Cally in Gloucester and many other individuals and organisations too numerous to mention. In 2004 the Effective Interventions Unit produced a document regarding good practice in the delivery of advocacy for people experiencing or recovering from drug dependency[3].

1 www.actionforadvocacy.org.uk

2 www.m-alliance.org.uk

3 Effective Interventions Unit (2004) Advocacy for Drug users: A guide

The Bristol Drugs Advocacy Service

In 2006 the User Feedback Organisation (UFO), a Bristol-wide service user forum, conducted a mapping exercise of advocacy services for Bristol's drug users. What was found was that many of Bristol's drug agencies provided some informal advocacy and support for their clients around a range of issues but that independent drug advocacy wasn't available for the majority of service users. This prompted the Drug Strategy Team, in partnership with interested people from the UFO and Community Action Around Alcohol and Drugs (CAAAD), to form a group to look at advocacy provision. A need for advocacy was established, and following a tendering process the Care Forum was commissioned to provide this service and I am employed as an advocate in this service.

> *"Advocacy is not a mediatory role as my job is to support the client, although in practice having a third party to assist in communication can have a mediatory effect"*

I am independently employed by the Care Forum to provide advocacy for Bristol's drug users. The Drugs Advocacy Service [DAS] offers a drop-in at Bristol Drugs Project together with Nilaari [a drugs project with a specific focus on reaching BME communities] and we are about to launch a new service, staffed by my colleague Anne Pickard, offering a drop-in at the one25 project [a service for women who sell sex].

Why do drug users need advocacy in primary care?

I believe advocacy can be useful in general practice to try to address the power imbalance between the patient and the GP. The issues an advocate might be involved in, include GPs being unhappy about maintenance prescribing [or any substitute prescribing], the withdrawal of substitute prescribing, or patients sometimes lacking communication skills or confidence to express what they need. Other issues can include problems around pain management for opiate dependent patients or other medical problems not being effectively treated, as any symptoms are explained away in the GP's mind as being drug related. There are of course some perennial issues such as patients being unhappy about the period of time they are kept on daily pick up/supervised consumption.

Advocacy is not a mediatory role as my job is to support the client, although in practice having a third party to assist in communication can have a mediatory effect. A common issue that professionals may have is the belief that a client's wishes for themselves may not be in their best interests. Our work is client led so when this situation arises, we would explore potential consequences of the actions, but would be duty bound to advocate unless a client was explicit about unethical/illegal intentions, e.g. wanting a higher dose of methadone in order to sell it. I have to take my direction from my client. This doesn't mean that we can't do some signposting or information gathering for our clients at times, where we think it may be in their best interests, but always with their agreement.

If the drugs field mirrors developments in the mental health field I believe that advocacy will become a well-established service for drug users and those in early recovery, to support service users to get their views recognised and their rights upheld. However, in Bristol formal advocacy for drug users is new - so time will tell.

Richie Moore, Drugs Advocacy Service Lead, Bristol Care Forum

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Paul Hayes **gives a view of drug treatment that explores the history of the development of treatment services and also examines the challenges that services face today - including the potential effects of the abstinence/maintenance debate, and the need to increase and evidence the quality** of services. **Ed.**

A view on drug treatment

The 'maintenance-versus-abstinence' debate is no longer confined to this newsletter or to those in the drug treatment sector. It features in the pages of Sunday newspapers, the discussion boards of influential think tanks, and the airwaves of national radio.

Those involved in treating people with drug misuse problems know that the polarisation presented in the media does not accurately reflect the reality of the current drug treatment system. Practitioners work hard to ensure that individuals are supported to access the type of treatment they need, when they need it. No one type of treatment is going to work for every user, every time. Overcoming addiction can be a long and painful journey, and the role of the National Treatment Agency (NTA) is to ensure that the doors to recovery remain wedged open.

> ***"The real challenge we face at this point is to ensure that we match quantity of service provision with quality"***

Drug treatment provision in England has come a long way since the NTA was created in 2001, and drug misuse has changed dramatically since abstinence was the dominant practice thirty years ago.

In the mid-1980s, Margaret Thatcher's government took the decision to focus drug strategy on harm reduction, as the existing abstinence-based system had buckled under the strain created by the availability of cheap heroin. The actions taken then succeeded in holding down HIV infection rates, and built the foundation for further additional investment under Labour with the overt aim of using drug treatment to reduce crime.

The drug treatment system created to meet the challenges of the twenty-first century has much to be proud of, and is unrecognisable from the system I first worked with thirty years ago. Now virtually anyone who chooses to access treatment in England can get it, and quickly. It strives to offer a balance of treatment, which includes harm reduction services, substitute prescribing, psychosocial interventions, inpatient and residential treatments, and new approaches where appropriate. The NTA is looking forward this year to reporting on the pilots exploring treatment incentives, and publishing information on developments in psychosocial interventions.

As a core component of the treatment system, methadone has enabled thousands of people to regain control of their lives, improve their health and relationships, and reduce criminal activity. But for most people it is the first step on the road to recovery: not the end result. The government's aim for treatment is for the user to overcome addiction, however long that might take, and whichever types of treatment are used along the way.

Abstinence-based treatment should be one of the options available to users at a suitable point on their road to recovery, as part of a decision taken jointly with the clinician. The NTA has recently announced where an additional 2,000 places a year will be created in abstinence-based treatments, as part of £54m of capital grants from the Department of Health.

Presenting these approaches as an 'either/or' scenario misses the point, and risks undermining the consensus for a balance of provision which has been the cornerstone of treatment policy.

The real challenge we face at this point is to ensure that we match quantity of service provision with quality. Led by the new ten-year Drugs Strategy, launched last year, the NTA will be prioritising making the system more ambitious for users, so that those who can come off drugs, are supported to do so, at the right time and with the right back up. Aiming for abstinence cannot mean risking destabilising individuals, with the knock-on impact on their families and communities.

Targets based on quantity and time spent in treatment only give us part of the picture: what really matters is the difference treatment makes to individuals. That is ultimately the best assessment of what recovery means.

This is why the Treatment Outcomes Profile (TOP), part of the National Drug Treatment Monitoring System, is asking about the impact of treatment on drug users' lives in four key areas: drug and alcohol use, health, social functioning and offending. We have a shared purpose with GPs in improving the effectiveness of treatment, and we very much want outcomes for individuals to be the driver for improvement.

Ten years on from the first Drug Strategy we take nothing for granted. It is as important now to advocate for drug treatment, in all its forms, as it ever was. We must not lose sight of the reality that whilst we are making progress towards transforming drug treatment, there is still a long way to go to make treatment as effective as it can be. To achieve this we need to offer service users the treatment they need, not the treatment we 'believe' in, and ensure that the public are aware of the benefits this delivers to wider society.

Paul Hayes

Chief Executive, NTA

SMMGP welcomes the National Treatment Agency's development of the Treatment Outcomes Profile (TOP) as a move away from simply measuring numbers in drug treatment, regardless of the quality of the treatment and a move towards measuring how people are benefiting, or not, from the treatment they receive. TOP was recently evaluated favourably by those who were responsible for the development of the tool (Marsden et al, 2008, Addiction 103:1450-1460).

However, SMMGP has been experiencing increasing reports from members and practitioners in the field regarding concerns about the implementation of TOP including:

- **The relevance and effectiveness of the section on crime**
- **Primary care based treatment is often developed with the aim of seeing large numbers of patients and so the administration of TOP can have a big impact on your time- the more patients you see, the more TOP forms you need to fill in**
- **A of lack of ownership by both service users and service providers about the content and the need for the TOP form.**

An article by *Jenny Keen, GPSI,* Barnsley expresses some of these concerns. We would welcome comments on this article and on TOP on our on line forums

http://smmgp.groupee.net/groupee/forums/

Care plans, NDTMS and TOP: how they can adversely affect patient care

In a GP consultation with a drug user these days I often feel that I am at a considerable disadvantage with regard to providing top quality primary care. This is because so much of the consultation has to be devoted to data collection which has no real bearing on the patient's care: 'care plans', National Drug Treatment Monitoring System (NDTMS) and the Treatment Outcome Profile (TOP).

GPs are no strangers to care planning and indeed we are natural care planners: it is an essential skill of the job. In a standard consultation I take a history, examine the patient, take steps along the diagnostic pathway in my own mind and reframe these in a manner accessible to the patient in order to agree a joint plan for the way forward and a back-up in case things do not go according to plan. Often this may include liaison with other agencies and workers. A brief note sums this up to set the baseline for the next consultation, in which a further step will be taken along the diagnostic and treatment pathway. This is care planning. It is a skill which applies equally with patients who have cancer, childhood illnesses or any other condition.

> ***"Excessive data collection requirements can only be a barrier to GPs wanting to treat drug-using patients, and the burden of overlapping data collection for this group of patients needs to be addressed urgently"***

With a drug-using patient this process is not so simple. I am faced first with a data collection template which furnishes the NDTMS return. Next I have to complete a 'care plan' at predetermined intervals, which bears little relation to the real care planning process described above. More recently we have TOP: the additional task of repeatedly completing a questionnaire of sensitive data which will be used for monitoring purposes unrelated to the individual patient's care.

NDTMS has developed gradually as a replacement for the old notification system for addicted patients. However, it seems that smuggled in on the back of the simple notification of patients with addiction problems is a growing host of other data items collected for monitoring purposes.

No doubt this collection is politically important. However, the 3 monthly collection of data has made it so onerous that many GPs need the help of shared care workers or data officers paid for by DATs who have to spend significant amounts of time collecting this data set.

In addition to this there is now the regular burden of three-monthly face-to-face data collection for TOP. Like most GPs, I am intensely interested in the evidence base for treatment outcomes and in carrying out the peer-reviewed and ethically approved research that is needed to produce these. The outcome measurements of TOP, however, must always be in doubt: first because the untrained data collectors are placed under such intense pressure to collect the data from patients (whose consent to this collection and storage of their personal data is largely taken for granted) and secondly because the data collectors in this situation have a vested interest in the outcomes. This will become increasingly the case as the results of the monitoring begin to be used to evaluate performance and to compare services so that services may see their funding in the balance.

For these reasons the TOP data quality risks being extremely poor and would be unlikely ever to stand up to the scrutiny of peer review. In recent discussions with GPs who were filling in TOP forms themselves, one commented that he "didn't have time to fill it in during the consultation and waited and did them all together at the end". Another said that he "simply handed it to the patient and got them to fill it in" and one commented that the key workers were sometimes driven to filling the forms in over the phone.

However an even more important issue is that TOP can actively detract from patient care, even when the GPs are not spending valuable consultation time filling them in themselves. One General Practitioner with Special Interest (GPSI) commented that he had personally never seen a TOP form, but the key workers working with his service never had time now to do any real key working with patients who needed it because they spent their whole time chasing up all the patients every three months to fill in the TOP forms. Numerous others echoed this.

Excessive data collection requirements can only be a barrier to GPs wanting to treat drug-using patients, and the burden of overlapping data collection for this group of patients needs to be addressed urgently. It is ironic that drug users are often among the most needy of our patients and require more of our attention and time than non-drug users, but because of the excessive burden of form filling and paperwork for these patients the opposite is likely to happen.

In an increasingly data protection conscious world it can surely only be a matter of time before the patients themselves question this process and the need for so much personal data to be collected about them for purposes unconnected to their personal care. It is perhaps only because so many of our patients are vulnerable and disadvantaged that this has not already been challenged. Meanwhile we are in danger of losing the genuine consultation in a sea of box-ticking.

Dr Jenny Keen
GPSI, Barnsley

Linda Harris **outlines the response the Royal College of General Practitioners Substance Misuse Unit (RCGP SMU) has given to the National Treatment Agency with regards to the Treatment Outcome Profile (TOP) questions on crime. For the full article please visit our website www.smmgp.org.uk Ed.**

Response from the RCGP Substance Misuse Unit in relation to the Treatment Outcome Profile criminal justice question

Summary

The overwhelming view of professionals consulted suggests serious concerns with the TOP forms and particularly:

The majority of clinicians consulted do not wish to see the criminal record being tied to the medical record stating that "the statute of limitations should apply i.e. there should be no ongoing record of spent convictions and thus allegations or records of criminal activity on records beyond the usual period when they are deleted according to law".

Concerns regarding data reliability in relation to the crime question have in many areas called into question the veracity of other data collected by the system.

Many at The RCGP SMU would support consideration for any outcome monitoring question relating to criminal activity to be separated from the TOP data collection within the clinical record, and indeed from the whole clinical consultation.

In sharing this view with the NTA the RCGP SMU acknowledge that discussion of crime related issues will in the case of certain patients be necessary and will still take place as part of routine substance misuse clinical work, but that the recording of it will be filtered by the clinician's judgement based on what is necessary and relevant.

Linda Harris, Clinical Director, RCGP Substance Misuse Unit

For the full article visit www.smmgp.org.uk

April Wareham **highlights the concerning issue of the withholding of essential medications, including HIV medications, for drug users in custody. She explains the importance of issuing essential medications, and suggests some ways forward to ensure that drug users receive medication whilst in custody. Ed.**

Provision of HIV medication in police stations and the withholding of other essential medications for drug users in custody

Introduction

It was recently brought to the attention of our service that a known injecting drug user who is HIV positive was not allowed to take their HIV medication (or their methadone) whilst in custody in a police station in London. They were told by the attending doctor that "no medication is that time-dependant" and that as they would probably be released later that day, withholding medication wasn't an issue. This article aims to set out why this is not the case, and to highlight the more general issue concerning the refusal of essential medications to drug users in custody.

HIV medication and resistance

What is resistance?

Resistance to drugs occurs when the structure of a virus makes tiny changes that stop the treatment from working. These changes are called mutations.

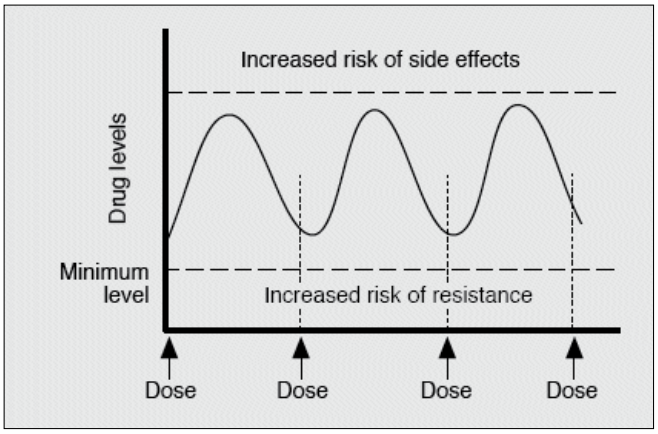
How can resistance be avoided?

Resistance can be avoided by using a combination of drugs that are strong enough to control the virus. This combination of medication needs to be taken at the specified time every day (known as adherence).

Missing doses, drug levels and resistance

Drug doses are calculated so that average drug levels are high enough to be active against HIV without risking resistance (see table 1).

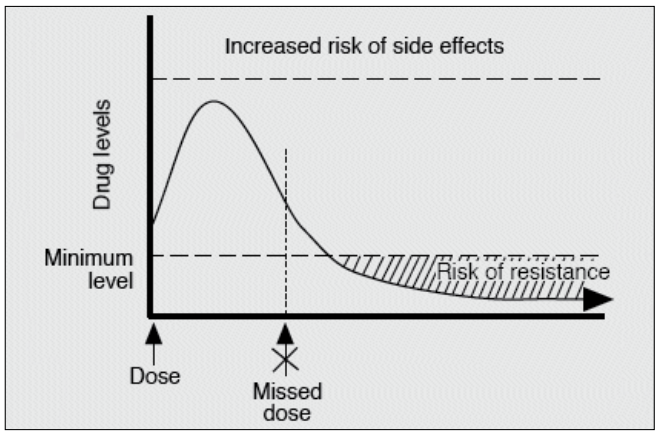
Table 1



A missed or late dose increases the risk of resistance

Missing or being late with a drug can result in the drug levels falling to a level where resistance can develop (see table 2). The more often someone is late with or misses a dose, the greater the chance that this will occur.

Table 2



What is adherence?

Adherence is a word used to describe taking medication exactly as prescribed. This involves taking medication at the right time. It also means following any special dietary restrictions (some HIV drugs need to be taken with food for absorption to occur, and others do not absorb properly when taken with certain types of food).

The introduction of highly active antiretroviral therapy (HAART) has substantially reduced HIV/AIDS associated morbidity and mortality. However, early optimism concerning the benefits of these medications has been tempered by evidence suggesting that even modest or occasional non-adherence can greatly diminish the benefits of treatment, leading to serious personal and public health consequences[1].

How good is good enough?

Unfortunately the answer is close to 100%.

Even missing just one or two doses can have a big impact on whether treatment is successful or not.

1 Garcia et al., (2002); Hogg et al., 1998; Ory & Mack, 1998; Palella et al., 1998

Research has clearly demonstrated that suboptimal adherence (i.e. taking less than 90-95% of prescribed doses) is associated with increased risk of adverse virologic and clinical outcomes, including increased viral replication and the development of drug-resistant HIV strains[2], as well as a host of clinically significant health-related setbacks[3].

Implications of non-adherence

If a patient becomes resistant to the combination of drugs that they are currently taking they become resistant to all the drugs in that combination. Another complication of non-adherence is cross-resistance. What this means in practice is that, as well as becoming resistant to a drug they have taken, patients also become resistant to other drugs in the same family. This can have serious implications for any future chances of managing their HIV infection.

Summary

Taking prescribed medication incorrectly can have seriously detrimental long-term consequences for anyone who is HIV positive. Just a single dose of medication being taken at the wrong time or with/without food can have an enormous impact on a patient's future ability to respond to treatment. This has implications for how HIV positive people should be treated within the criminal justice system.

Access to essential medication in custody for drug users - a wider problem?

Before writing this piece I began to speak to drug users, drug workers and peer led user advocacy groups and I found that this issue was not just about HIV medications. I found that the more I investigated the more 'horror stories' I uncovered. In speaking to drug users and professionals within the drugs field I heard stories of drug users being refused other essential medications. For example, one case reported to me involved a drug user being refused essential psychiatric medication. I have also heard more than one report of police officers removing and destroying injectable warfarin or interferon because they believed it was a Class A Drug "in disguise".

This is a problem that is relatively easy to solve by providing education and information to members of the criminal justice professions and to medical practitioners who work within these fields. A recent study from Brighton looked at how GPs felt about managing the primary care needs of people with HIV and found: three-quarters of GPs surveyed felt they lacked sufficient knowledge of HIV treatments and their side effects; almost half felt they lacked the necessary experience; and almost none wanted to take on the role of prescribing HIV medicines[4]. So *easy* is definitely a relative term.

Perceptions

I have found that amongst professionals there is an attitude that any medication a drug user has in their possession is viewed as a symptom of their addiction – "they must be able to get high on it".

Also, many people who are on daily medication (whether for HIV or for another medical condition) carry daily doses in unmarked pill boxes, making them difficult to identify. I understand that professionals are wary of a vulnerable person in their care overdosing or coming to some other harm – but when a police officer refuses to allow a prisoner to take their medication after a hospital consultant has spoken to them (the reason given being that "we don't know who is calling – it could just be your mate") – are we now into dealing with personal prejudices rather than protecting vulnerable people?

What is essential medication?

I think that most people would agree that HIV medication is essential - and also that psychiatric medications are essential. Before we get into discussions of which medications are and aren't essential we should look at the medications that the World Health Organisation consider essential. Essential medications are either on the core list or the complementary list. The complementary list presents essential medicines for priority diseases, for which specialised diagnostic or monitoring facilities and/or specialist medical care, and/or specialist training are needed. Both methadone and buprenorphine are listed on the complementary list as medicines used in substance dependence programmes. There is also an acknowledgement that they should be used within an established treatment programme[5].

The way forward – examples of best practice

There are areas of the country where arrest referral workers are able to collect methadone/Subutex from local pharmacies on behalf of clients who are currently in police custody and who are involved in an established treatment programme. Of course this only makes a difference to those already on an opiate substitution therapy prescription – but what a difference!

What do drug users want?

From the chapter *What do Drug Users need from the General Practitioner?* Alan Joyce of the Alliance comes to the conclusion:

"In many respects these needs are not so different from the problems non-drug using patients would reasonably expect their general practitioner to recognise and deal with" [6].

So the answer really is ***the same as anyone else,*** including access to their prescribed medication.

In summary, what drug users want from medical care within the criminal justice system is the same care any other citizen can expect, without prejudice, perception or stigma interfering with the quality of their care.

April Wareham Service User Advocate

Graphs and other information from i-base treatment guides www.i-base.info

For related reading:

HIV Positive Women in Prison: Positively Women Magazine "HIV v HMP" May/June 2002: extract available at www.positivelywomen.org.uk/images/newsletter/2002mayjune.pdf

HIV Positive Prisoners in Canada (research extract): Incarceration and implications for HIV treatment among injection drug users

www.i-base.info/idu/2007/en/oct07/Incarceration.html

2 Gifford et al., (2000); Liu et al., 2001; Wainberg & Friedland, 1998

3 Paterson et al., (2000)

4 Kennedy et al (2008) Understanding the Barriers to GP Involvement in the Care of Patients with HIV", HIV Medicine, Volume 9 Suppl 1, 06 and P2

5 World Health Organisation (2007) Model List of Essential Medications, 15th List

6 Berry Beaumont ed (2004) Care of Drug Users in General Practice

continued from page 1…

Anabolic steroids

Introduction

Anabolic steroids are a diverse group of drugs that mimic, to varying degrees, the actions of endogenous testosterone. For the last 50 years the use of these drugs within elite sport (along with a diverse number of other performance-enhancing substances) has been a concern for sports authorities. However, the reality is that use of these drugs in elite sport represents only a tiny fraction of the total number of users in the general population.

Who uses anabolic steroids and why?

As is the case with users of any substance, those using anabolic steroids are not a homogenous group. The vast majority of users are male, with female use limited to a small number of competitive bodybuilders and sportswomen[1,2]. Whilst the reasons why people choose to use anabolic steroids are often complex and diverse it is possible to consider them in three broad categories, although it is important to note that these are not mutually exclusive and the main reason for use may change overtime: 1) Professional athletes and sportspersons who use predominately in order to enhance their sporting performance. 2) Occupational users, such as those in the security industry (e.g. door supervisors and security guards), prison officers and police officers whose major reasons for use are to increase both body size and aggression in order to protect and intimidate others. There are also those in the entertainment industry, such as dancers and actors, who use to enhance their physique as required by their occupation. 3) Body image users whose primary aim is to increase muscle mass and, hence, body image satisfaction.

When interacting within a health setting with steroid users or those contemplating use it is helpful to be aware of the motivations for use, as this will ultimately impact on the intervention provided. A seventeen-year-old male who wishes to look good on the beach and is contemplating using anabolic steroids may be receptive to discussions relating to improved training and nutrition in order to attain his goals. However, for the competitive bodybuilder with ten years experience of anabolic steroid use, safer injecting advice and health monitoring may well be more appropriate and acceptable.

How are anabolic steroids used?

Anabolic steroids are commonly used in self-directed, high dose, polydrug regimens based on a function of availability, cost, personal goal, self-experimentation and local culture. The latter two tend to be based on a diverse range of information sources that include other steroid users in the gym, steroid handbooks, magazines, and the internet. Parenthetically, it is important to note that in the UK the possession of anabolic steroids for personal use is legal.

Whilst there is considerable interpersonal heterogeneity in these regimens, there are three central tenets practised by the majority of users; cycling, stacking and the use of ancillary drugs[3].

“A seventeen-year-old male who wishes to look good on the beach and is contemplating using anabolic steroids may be receptive to discussions relating to improved training and nutrition in order to attain his goals. However, for the competitive bodybuilder with ten years experience of anabolic steroid use, safer injecting advice and health monitoring may well be more appropriate and acceptable”

Cycling is where anabolic steroids are taken for a number of weeks (‘on cycle’ which is typically 6–12 weeks), followed by a period of drug-free training (‘off cycle’). Users’ rationale for this cyclical practice is to prevent tolerance to the steroids and to limit the potential for side effects.

Alongside cycling, users will also usually take two or more anabolic steroids concomitantly in a practice known as stacking. The rationale here is that, given the different pharmacological profiles exhibited by steroids, taking multiple types will have specific, additional or synergistic effects. Finally, users will often draw from a diverse pharmacopoeia of ancillary drugs that include other performance-enhancing drugs, drugs taken as both prophylactics to and for the treatment of steroid-induced side effects, and the use of recreational drugs that may also serve to enhance performance or as relaxants. Indeed, in regards to the latter, data from a sample of users from Merseyside found the prevalence of cocaine use to be substantially higher amongst steroid users than that in the general population[4].

How many people use anabolic steroids in the UK?

There is a lack of data on the prevalence of anabolic steroid use in the United Kingdom, primarily because of the low priority this form of drug use has within policy. Indeed, the sole mention of this issue within the National Drug Strategy is within the context of “those who tarnish our national image by cheating in sport”[5].

Prevalence studies have for the most part been limited to local surveys[16] with the only national study completed some 18 years ago which found that from 1,667 participants drawn from 21 gyms from across England, Wales and Scotland, 6% of men and 1.4% of women were current users of anabolic steroids[7]. The British Crime Survey, the mainstay of drug use estimates used to inform government drug policy, has recently reported a reduction in steroid prevalence between 1998–2008, with lifetime use estimated to be 200,000[7]. However, needle and syringe programmes (NEPs) across the UK tell a different story. In Merseyside and Cheshire the number of new steroid-injecting clients attending agency-based NEPs between 1991 and 2006 increased seven-fold, whilst overall during this period there was a 2000% increase in the number of steroid injectors attending exchanges[8]. For the past three years, new clients injecting steroids have outnumbered new injectors of all other drugs combined. Furthermore, analysis of injecting equipment transaction data and interviews with the clients themselves indicate a high level of peer distribution of injecting equipment, which suggests that anabolic steroid users attending these services may be only the “tip of the

1 Korkia, P., & Stimson, G. V. (1993). Anabolic steroid use in Great Britain: an exploratory investigation. A report to the Department of Health, the Welsh Office and the Chief Scientist Office, Scottish Home and Health Department. London, United Kingdom: Her Majesty’s Stationery Office.

2 Lenehan, P., McVeigh, J., & Bellis, M. A. (1996). A study of anabolic steroid use in the North West of England. Journal of Performance Enhancing Drugs, 1 (2), 57–70.

3 Dawson, R. T. (2001). Drugs in sport – the role of the physician. Journal of Endocrinology, 170 (1), 55–61.

4 McVeigh, J. (2008). Anabolic steroids and associated drugs: Public health implications and harm reduction. 19th International Conference on the Reduction of Drug Related Harm, Barcelona, Spain.

5 HM Government. (2008) Drugs: protecting families and communities. The 2008 drug strategy. London, United Kingdom: HM Government.

6 Williamson, D. J. (1993). Anabolic steroid use among students at a British college of technology. British Journal of Sports Medicine, 27 (3), 200-201.

7 Hoare, J. & Flatley, J. (2008). Drug Misuse Declared: Findings from the 2007/08 British Crime Survey England and Wales. London: Home Office.

8 Evans-Brown, M. J. & McVeigh, J. (2008). An introduction to anabolic steroids. Sport EX medicine, 38 (Oct), 20–26.

iceberg" [9]. To what extent these data reflect an increase in use or merely an increased uptake of syringe exchange services is unknown, however it does provide an indication of the extent of use of these drugs.

The risks to health

The use of anabolic steroids has been associated temporally with a diverse number of adverse effects on both physical and psychological health which, on occasion, have been fatal[10]. However, this area remains under researched, with the evidence base over reliant on data from self-reported side effects and case reports.

Anecdotal data suggests that the majority of the anabolic steroids available in the UK are substandard, including a large number of counterfeit and fake products. This does not mean that they do not contain anabolic steroids, but they may not be the specific drug they purport to be[11], nor the strength specified on the packaging[12]. Counter-intuitively, illicitly produced anabolic steroids may contain higher levels of active ingredients than legitimate products[14]. As many of the associated adverse effects of anabolic steroids are dose related, this further complicates efforts to minimise the adverse effects of these substances. An additional concern regards the sterility of these drugs[13]. As the vast majority of anabolic steroid users inject [2], they are also at risk of bacterial infections at the site of injection[14]. For those who share injecting equipment (or re-use injecting equipment and, subsequently, share multi-dose vials with others), blood-borne viruses such as HIV, hepatitis B and hepatitis C are genuine risks[15 16 17]. The issue of blood-borne virus transmission is compounded by the fact that the majority of users report increased libido as a result of steroid use[1 2], which could increase the potential for their transmission (and that of other sexually transmitted infections) if users engage in risky sexual behaviour.

Harm reduction

There is a paucity of robust evidence relating to the risks of adverse health effects as a result of steroid use. This is coupled to the fact that for many years the medico-scientific community repudiated the performance-enhancing effects of these drugs[18], and promulgated unsubstantiated views of the dangers of these drugs. No doubt this was done with the best of intentions, but such views have not been matched by steroid users "dropping like flies"[19]. These factors have limited the trust and credibility that many steroid users place in health professionals. Compounding this lack of trust is the demonisation of steroids and users by the media and wider society, as well as the fact that government policy has been directed predominately by anti-doping efforts within elite sport [4]. This has left the majority of steroid users marginalized and apart from the provision of sterile injecting equipment (predominately through syringe exchange services), limited opportunities have been developed for this population to engage with health professionals to reduce harm and promote health. Ultimately, as a result, users have had to rely on 'locker-room anecdotes' (both within gyms, and, increasingly, through the internet).

> ***"Anecdotal data suggests that the majority of the anabolic steroids available in the UK are substandard, including a large number of counterfeit and fake products"***

It does appear, however, that there are a significant number of users who would welcome engagement with health services[1 3] — in a context-sensitive, non-judgemental manner that meets their needs. This will require that we firstly explore new ways of engaging with this population, which should start with listening to them, and providing them with an environment where they can articulate, prioritise and reflect on their concerns and needs. Additionally it requires that health professionals have the relevant skills and knowledge in place, in order to work with steroid users. Correspondingly this requires that we further develop the evidence base on both the positive and negative effects of steroid use. Indeed, in response to local need, some specialist services have been developed in the UK. For example, the Drugs In Sport Clinic and Users' Support (DISCUS) in Tyne & Wear provide medical, dietary and harm reduction services. However, these services are the exception rather than the rule.

Until such services become more widely available as a minimum there should be provision of sterile injecting equipment and basic harm reduction advice universally available in a format appropriate for steroid users.

In the United Kingdom, anabolic steroids (along with the related drugs clenbuterol, growth hormone and chorionic gonadotrophin) are controlled as Class C drugs under Schedule 4, Part II of the Misuse of Drugs Act 1971. Possession for personal use is legal if in the form of a medicinal product (including import and export). However, supply (including giving or sharing), intent to supply and production are illegal and punishable with up to 14 years imprisonment and/or an unlimited fine.

Developed at the Centre for Public Health, Liverpool John Moores University, s.teroids.net is an online discussion forum that facilitates the sharing of research, good practice and information around anabolic steroids (and ancillary drugs). It supports the dissemination of academic research results in a form that is both accessible and practical for health professionals engaging with users. *www.s.teroids.net*

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Don't miss the full article at www.smmgp.org.uk

For more advice on steroids see Dr Fixit, page 19. Ed.

9 McVeigh, J. (2008). Public health implications of anabolic steroid use. The 13th National Conference: Management of Drug Users in Primary Care. Brighton, United Kingdom.

10 Hartgens, F., & Kuipers, H. (2004). Effects of androgenic-anabolic steroids in athletes. Sports Medicine, 34 (8), 513–554.

11 Musshoff, F., Daldrup, T., & Ritsch, M. (1997). Black market in anabolic steroids — analysis of illegally distributed products. Journal of Forensic Sciences, 42 (6), 1119–1125.

12 Perry, H. (1995). Counterfeit-fake anabolic steroids and hazards of their use. Relay, 1 (4), 9-12.

13 Bergman, R. T. (1993). Contaminated drug supply. The Physician and Sportsmedicine, 21 (2), 8.

14 Perry, H. (1995). Counterfeit-fake anabolic steroids and hazards of their use. Relay, 1 (4), 9-12.

15 Dickinson, B. P., Mylonakis, E., Strong, L. L., & Rich, J. D. (1999). Potential infections related to anabolic steroid injection in young adolescents. Pediatrics, 1999, 103 (3), 694.

16 Rich, J. D., Dickinson, B. P., Merriman, N. A., & Flanigan, T. P. (1998). Hepatitis C virus infection related to anabolic-androgenic steroid injection in a recreational weight lifter. The American Journal of Gastroenterology, 93 (9), 1598.

17 Health Protection Agency, Health Protection Scotland, National Public Health Service for Wales, CDSC Northern Ireland, and the CRDHB. (2008). Shooting Up: Infections among injecting drug users in the United Kingdom 2007. London: Health Protection Agency.

18 Taylor, W. (1991). Macho Medicine. A history of the steroid epidemic. London, United Kingdom: McFarland & Company. pp. 24–33.

19 Yesalis, C. E., Wright, J. E., & Bahrke, M. (1989). Epidemiological and policy issues in the measurement of the long term health effects of anabolic-androgenic steroids. Sports Medicine, 8 (3), 129–138.

Hot off the press: NICE guidance on needle and syring programmes! Watch out for our comments in the next SMMGP policy update. Ed.

National Institute for Health and Clinical Excellence

Tel: 0845 003 7782
www.nice.org.uk

Ref : 2009/011

ISSUED: 19 FEBRUARY 2009

New NICE guidance promotes benefits of needle and syringe programmes

New NICE guidance being published on 25 February 2009 aims to reduce the transmission of blood borne viruses through the optimal provision of needle and syringe programmes (NSPs). With an estimated 150 000 - 200 000 injecting drug users within the UK, this guidance highlights the important role these programmes can play in tackling the spread of viruses, including Hepatitis C and HIV, and helping drug users to access further treatment.
Needle and syringe schemes have been provided throughout England for over 20 years with the majority being run by pharmacies and other drug services. NSPs work by providing injecting drug users with sterile injecting equipment and advice on safer injecting practices and appropriate disposal techniques. They also act as an effective conduit through which healthcare professionals are able to have direct contact with, what are often considered to be hard to reach groups. This direct contact allows NSP staff to explain the many dangers of drug misuse and the possible treatment pathways open to them, including access to services to help them stop injecting drugs such as opioid substitution therapy (OST).

By highlighting the importance of needle and syringe programmes and explaining how they can operate effectively – for example by increasing the accessibility of schemes in terms of opening times, locations and the services they provide - this guidance aims to encourage their use amongst existing injecting drug users.

Recommendations include:

- Encouraging people who inject drugs to use services which aim to: reduce the harms associated with injecting drug use; encourage them to stop using drugs or to switch to non-injecting methods (for example, opioid substitution therapy); and address their other health needs.
- Advising local health authorities on how to develop plans to ensure NSPs meet local need and offer integrated care pathways for people who inject drugs.
- Helping NSP providers develop plans for needle and syringe disposal, in line with 'Tackling drug-related litter' (Department for Environment, Food and Rural Affairs 2005).
- Guidance on the provision of needles, syringes and other injecting equipment to people who inject drugs.
- Ensuring people who use NSPs are provided with sharps bins and advice on how to dispose of needles and syringes safely.

Professor Mike Kelly, NICE Public Health Excellence Centre Director said: "Evidence shows that needle and syringe programmes are not only an effective way of tackling blood borne viruses among injecting drug users but that they also actually save the NHS and public sector money. Estimates suggest that the cost to the NHS of caring for someone who injects drugs is around £35,000 over their lifetime. From a societal perspective, the average cost rises to an estimated £480,000 over the lifetime of each injecting drug user when you take into account the high cost of crime, including criminal justice system costs."

Dr David Sloan, Vice-chair of the Public Health Interventions Advisory Committee (PHIAC) and Former Director of Health Improvement & Public Health for City & Hackney Teaching Primary Care Trust said: "Although HIV rates remain relatively low among injecting drug users in the UK, bad practice, such as the sharing of needles among multiple users, makes these individuals extremely vulnerable to any future outbreak. This is not a time for getting complacent and our guidance on the optimal provision of NSPs will help to ensure the spread of blood borne viruses, not just within the injecting drug user community but also society at large, remains under control. Needle and syringe programmes also provide an important route into treatment and safer alternatives to injecting."

Colin Bradbury, Treatment Delivery Manager, National Treatment Agency for Substance Misuse (NTA) said: "The NTA welcomes this guidance as needle and syringe programmes are an essential element of the balanced drug treatment system advocated by NICE. Needle and syringe programmes, particularly when used in conjunction with substitute prescribing, are an effective means of reducing the risk of HIV and changing injecting behaviour. This publication complements the full suite of NICE guidance on drug treatment, which says local services should have a range of interventions available to tackle drug misuse, including harm reduction services, substitute prescribing, and abstinence orientated drug treatment."

Dr Mathew Hickman, Chair of the Hepatitis C Prevention Working Group, Advisory Council for the Misuse of Drugs explained: "Needle and syringe programmes are a critical component of public health action to prevent Hepatitis C infections amongst injecting drug users. Evidence suggests that a combination of interventions is most effective. This means that NSP staff need to use the opportunity they have with injectors actively to promote and refer people into treatment, such as opiate substitution programmes. These programmes should also ensure that sterile injecting equipment is available for people using the service."

Ends

For more information call the NICE press office on 0845 003 7782 or 07775 583 813.

Notes to Editors

About the guidance

1. Information on this guidance can be found on the NICE website at – http://www.nice.org.uk/Guidance/PH18

About NICE

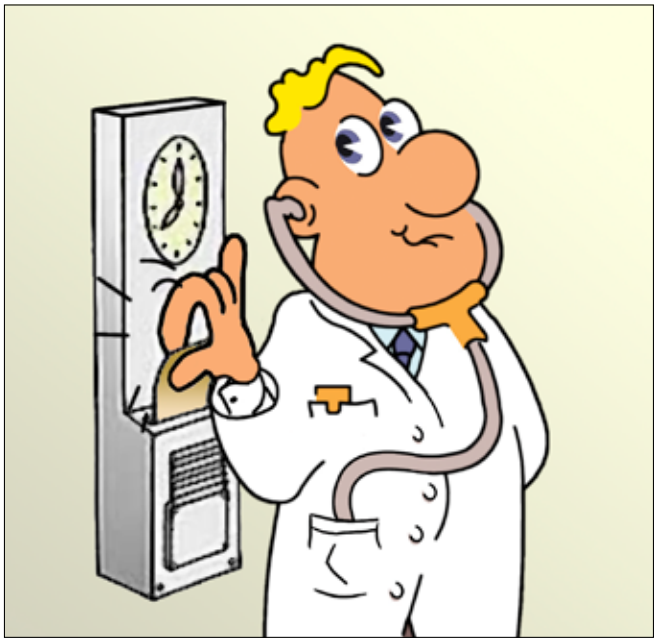
2. The National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

3. NICE produces guidance in three areas of health:

    - public health – guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector
    - health technologies – guidance on the use of new and existing medicines, treatments and procedures within the NHS
    - clinical practice – guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS.

Tim Horsburgh **and** ***Kate Beale*** **argue that employment can be an important stage in drug users' recovery and they discuss the approach Dudley has taken to support service users into training, education and employment. By taking a multi agency approach they have improved care pathways in Dudley for those using drugs to access services that can help them to find work. Ed.**

Education and employment – the best treatment?



It is recognised that in order for a drug user to succeed on their journey, medical and psychological interventions alone are not enough[1]. To enable full social re-integration the client may need support with housing, education and training, both for the drug-free and for those stable on substitute medication[2]. Barriers such as prolonged supervised consumption and rigid review schedules need to be addressed to allow clients to access education and the job market.

Clearly, our client group have significant barriers to employment, including low levels of educational achievement, often due to school truancy[3 4]. Poor literacy and IT skills are also common and are often associated with perceptions of authority[5]. Many have low levels of skills training, limited work experience, a history of offending and low self-esteem. Mental health problems also affect our clients and coping with the routine of work may prove challenging. However, attaining work enhances social skills development, reduces boredom, improves self-worth and increases income, with the associated health benefits involved in these gains. A more positive job-related identity may also help drug users attain long-term success and reduce the likelihood of relapse.

The National Drugs Strategy 2008[1] indicates a shift in government policy towards "delivering new approaches to drug treatment and social re-integration" by offering "training and support in getting work". There is also a commitment to "use the benefits system to support this new focus of re-integration, providing the right level of support for people with drug problems to move towards treatment, training and employment". From April 2009, Job Centre Plus (JCP) will introduce local co-ordinators in each district to aid pathway integration for drug users seeking work and for JCP customers who need a drug service.

> ***"attaining work enhances social skills development, reduces boredom, improves self-worth and increases income, with the associated health benefits involved in these gains"***

Policy, research, and targets support the links between drug treatment and employment services. The National Drugs Strategy supports the use of pilot projects using pooled budgets and individual budgets to offer training and employment support to achieve positive client outcomes. The Department of Work and Pensions (DWP) changes to Incapacity Benefits in October 2008, with the launch of the Employment and Support Allowance (ESA), will impact on these developments. A key aim of changes suggested by the DWP is to incentivise people with drug problems to move towards treatment, training and employment. Research also supports the relationship between treatment and employment; successful completion of treatment significantly improves the probability of employment after treatment[6]. The Public Service Agreement 2008 – 2011 targets relating to National Indicators NI117 and NI 150 also provide incentives to areas to encourage drug users into employment.

Positive drug treatment outcomes for drug users often involve new ways of living, providing the opportunity for discovery of the potential for new skills, including the achievement of self-respect that economic independence can bring. Employment and skills targets can only be achieved if positive progress is made with those entering treatment for drug misuse. The individuals in treatment are an important target group for movement into employment, given that many users have not fulfilled their potential nor achieved accredited awards for the skills that they do possess. These are the same positive steps that are necessary for people to take to move away from re-offending.

A model of social support integration has been developed in Dudley, West Midlands over the past 2 years building on previous good work locally in this field (the regional re-offending partnership action plan provided a platform for this initiative). Integrated social support models have been shown to improve client employment outcomes[7].

1 H M Government (2008) – 'Drugs: Protecting families and communities 2008 - 2018 strategy' HMO

2 Platt J. et al. (1998) The case for support services in substance abuse treatment. American Behavioural Scientist Vol. 41, No. 8 1050 – 1062

3 Henry K.(2006) Who's Skipping School: Characteristics of Truants in 8th and 10th Grade. Journal of School Health Vol 77, Issue 1, Pages 29 – 35

4 Wu L. et al. (2003) The relationship between employment and substance use among students aged 12 to 17*1. Journal of Adolescent Health Vol. 32, Issue 1 , Pages 5 – 15

5 AI Crime reduction matters(2004) Does drug use cause crime ? understanding the drugs – crime link. 1 no. 22 ISSN 1448-1383

6 Zarkin G. et al. (2002) The effect of treatment completion and length of stay on employment and crime in outpatient drug-free treatment. Journal of Substance Abuse Treatment Vol. 23. 261 -271.

7 Joshua A. Room M.A.A. (1998) Work and Identity in Substance Abuse Recovery. Journal of Substance Abuse Treatment Vol. 15. 65 – 74

The National Treatment Agency, the Regional Offender Manager, Jobcentre Plus, and the Learning and Skills Council (LSC) in the West Midlands region recognised that they each had a vested interest in achieving positive outcomes with the same group of people.

This shared commitment meant that drug treatment services needed to move away from dependence on small short-term specialist projects, and towards finding pathways to mainstream provision through which users in treatment could be supported towards skills and employment. Specialist services could then genuinely specialise where specialist skills and time are needed.

Dudley proved a positive environment for this shared commitment to be put to work. The need was clear with significant numbers of problematic drug users in the area receiving treatment (over 1100 in the first 10 months of 2007-8). Enthusiastic local leadership was available from Jobcentre Plus, Turning Point (a voluntary sector service providing structured day care and Progress 2 Work) working with the local treatment provider (The Warehouse) and the probation service. The LSC were also able to bring Further Education colleges into the partnership.

Two pieces of work were identified to establish the basis for more effective joint working. First, it was important to get a more detailed picture of levels of need and readiness within the population of users in treatment. Success would only come if all partners and the users themselves could work to realistic targets that would challenge users but would not set blanket targets that took no account of the impact of drugs on the capacity to learn or establish stable life patterns.

To tackle this, the local treatment service undertook a snapshot survey of needs amongst users who were seen in treatment during August 2006. The strategy was deliberately intended to be simple and indicative rather than over-complex and time consuming. Partners needed a good enough indication to support their work together. This approach has enabled the survey to be replicated in two other parts of the West Midlands region, thereby building a progressively more robust understanding of levels of benefits dependency, readiness for work, and needs for 'skills for life'.

Second, local agencies needed to find ways in which they could make explicit and visible how shared case management between the different services could be delivered. Helped by a consultant skilled in working with business processes, the local services have developed a shared process map that can enable all staff to improve the ways in which they work with drug users to deliver coherent case plans. The mapping work has set out:

- How existing provision to improve offenders' skills for life developed through probation and the LSC could be well used for offenders in drug treatment
- How referrals between Jobcentre Plus, guidance services and drug treatment services can be encouraged and managed.
- How the work of the specialist employability service in the Borough can support good joint working rather than find itself making up for failures in mainstream provision.

The process has already improved working relationships between agencies and at a launch event on 11th April 2007, a broad group of local services met together to identify how this work can move forward. All concerned know that this has just been the start of real outcomes being delivered for drug users, and for the health and safety of the local community.

Positive outcomes in Dudley:

> Closer working between multi-agency partners

> Process map designed and in use by partnership agencies

> 544 referrals to Turning Point (April 07 / March 08)

> 284 assessments

> 37 into employment

> 54 into training or education

> 23 sustained in employment or training over 13 weeks

> Positive feedback from regional NTA regarding the pilot site

Recommendations:

> Raise awareness of organisational priorities in local area

> Develop effective working relationships between partners at all levels

> Introduce a process map

> Develop a liaison forum to monitor, review and update

> All boroughs should have Education Training and for Employment (ETE) support for drug users

> Provide a local process map in induction training for staff

> GP shared care schemes should include training / employment pathways

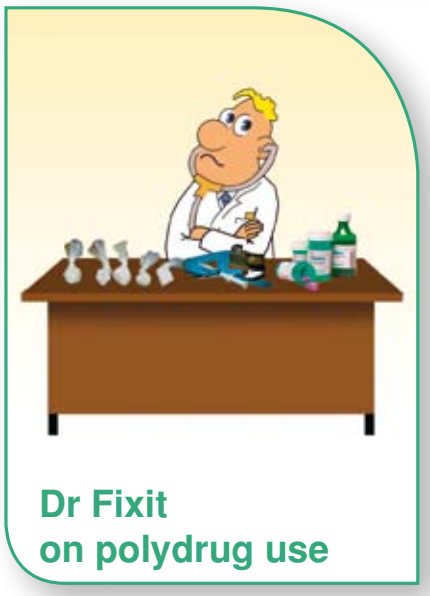
> Post-employment support for clients is required

> Re-referrals at any stage should be made swiftly

The pilot project indicated clearly to all stakeholders the benefit of supporting clients into education and employment and the significant contribution this makes to clients' ability to integrate back into society.

Kate Beale - Team Leader - Turning Point (kate.beale@turning-point.co.uk)

Dr. Tim Horsburgh - Clinical Lead.
(tim.horsburgh@dudleywarehouse.org)



Dr Fixit on polydrug use

Vanessa Crawford provides an answer to a GP seeking advice about a patient who is a polydrug user. Ed.

Dear Dr Fixit

I wonder if you could help me with Michael? I have been working with him at the practice for a couple of months. When he first came he was using everything - if there was a drug to use Michael would use it! He was spending up to £150 daily on a combination of cannabis, heroin, which he injects, and crack which he smokes. He lives in a hostel and works in the building trade which takes him all over the place and has made it difficult for him to attend his appointments.

Within a few weeks he settled on 90mg of methadone mixture and his urine was negative for heroin, but continued to be positive for cannabis and cocaine. He is completely open about the scale of his polydrug use and is concerned about his increasing crack use. He binge drinks up to 2 bottles of vodka a day to come down after a period of heavy use of crack.

His health is beginning to suffer and he is losing weight. He is working less and he is getting more and more into debt. He doesn't want to stop but he wants help to manage his use. Michael has been screened and he is HCV positive but PCR negative, HBV immune and HIV negative.

He doesn't want to go into residential care and he hasn't managed to stay in the crack day-programme. His keyworker thinks I should stop his methadone because he is continuing to use. I don't want to, and worry if I did that he would drop out of treatment.

Can you please help? How can I manage Michael?

Answer provided by Vanessa Crawford
Consultant Psychiatrist / Clinical Director, East London Specialist Addiction Service, Associate Dean for Psychiatry.

Many thanks for your request for advice regarding the management of Michael. Firstly, I think you and Michael have done extremely well to reach a stable methadone dose with no overt heroin use in such a short time.

I would like to think about Michael's care in terms of short and long-term management and divide this into the biological, psychological and social aspects of his care.

In the short-term we particularly need to think about Michael's physical health. The weight loss could be due to a number of serious conditions e.g. tuberculosis, HIV, diabetes. I'm sure you have completed a thorough medical history and physical examination but it's easy to forget tuberculosis and / or blame weight loss on his crack use. He is lucky to be HCV PCR negative but he clearly needs plenty of harm reduction advice about his crack use.

The urine drug screen result confirms that he has made significant changes to his heroin use. The continued crack cocaine and alcohol use is, however, particularly worrying. The risk of cardiovascular problems with his use of crack cocaine and the risks that his level of alcohol intake poses, including the risks of overdose with his combined use of alcohol and methadone, should be discussed with Michael. Has stopping heroin led to an increase in his crack and alcohol use? Would an increase in his methadone dose lead to any reduction in his drinking or crack use? It would be important to explore the patterns of crack and alcohol use; your question suggests that he drinks because he uses crack. What does he think would happen if he did not use crack every day - would that mean he would not drink every day? Or is he physically dependent on alcohol, and is it possible that the risks of suddenly stopping may lead to him experience seizures and delirium tremens? If he is not physically dependent on alcohol, could he push himself a little to achieve some more 24-hour periods of being alcohol and crack free? Can he contemplate having some crack free days? Is his cannabis use significant at this point or something to be kept for a later discussion?

I would encourage trying to engage Michael by not expecting him to attend more than one service if at all possible initially. If he is not already on daily supervised consumption this may be worth considering so that he can also be monitored by the dispensing pharmacist. He needs to be given positive feedback on the changes he has made, whilst ensuring he is aware of the risks he is taking.

Look at his risk patterns, his support networks and any possible extra support he could be given regarding his social situation. Are there any child protection issues to be borne in mind? Discuss with him the pros and cons of continuing to work whilst tackling such big issues, in addition to the safety aspects of the nature of his work. Can the key worker support him with his housing issues and is there a significant person in his life that it may be helpful to have a joint meeting with to give him extra support? Given the key worker's original view on stopping the script, a joint discussion with the key worker around the philosophy of engagement and harm reduction would be useful.

Considering the longer-term, have a think about who would explore Michael's background history in some more detail, if it has not already been done, to try and get a better understanding of why he started, and continues, to use drugs and alcohol problematically. Is there a history of abuse, physical, sexual or emotional and does it need further exploration? Is this something that has been common in his family? Are his current social issues maintaining his addiction and is there any need, desire and indeed possibility for these to change? He is at a very early stage in treatment and needs support. He may well move towards residential treatment in time, if appropriate.

It may also be worth discussing the case with someone with more experience in substitute prescribing, for example a GPwSI/ a local specialist doctor if you are looking for further management advice in the future.

Dr Fixit on steroids

A GP asks Dr Fixits *Jim McVeigh* and *Michael Evans-Brown* for help with a patient who is using steroids. Ed.

Dear Dr Fixit

Tom is a 19-year-old patient who has seen me in the past to discuss how to 'put on muscle'. For the past year he has been training regularly at the local gym. At our last appointment he told me he has been using anabolic steroids regularly but that recently he has noticed changes in the tissue of both his breasts. On examination he appeared to be developing gynaecomastia. Tom said that he had been told by people in the gym that there are drugs that could be taken to prevent and treat this side effect.

I am feeling out of my depth as I really don't have the knowledge to advise him about what to do. Can you help?

***Answer provided by Jim McVeigh,** Head of Substance Use and Reader in Substance Use Epidemiology at the Centre for Public Health, Liverpool John Moores University and **Michael Evans-Brown,** Researcher in Performance-Enhancing Drugs at the Centre for Public Health, Liverpool John Moores University.*

What you have described does sound like the early stages of anabolic steroid-induced gynaecomastia. In fact it is one of the most commonly reported side effects amongst individuals using anabolic steroids. Often referred to as "bitch tits" by users, it is the growth of the glandular breast tissue in males thought to be caused by an imbalance in the ratio of free oestrogen to testosterone. This imbalance is mediated, in part, by the conversion of many exogenous anabolic steroids to oestrogens in the body (a process known as aromatisation). It is also thought that the disruption of the normal binding of endogenous oestrogen and testosterone to sex hormone binding globulin by some anabolic steroids plays a role in this imbalance. Gynaecomastia is not unique to anabolic steroid users, being a common physiological occurrence in neonates (65-90%), pubertal boys (up to 60% by age 14), and older males where there maybe an imbalance in endogenous free oestrogen and testosterone ratio. There are also a diverse number of disease states associated with gynaecomastia, including: pituitary disease, genetic causes, cirrhosis, and Leydig cell tumour. Furthermore, the condition is also associated with a large number of other drugs in clinical use, including, importantly in Tom's case, human growth hormone, human chorionic gonadotrophin and spironolactone (a potassium-sparing diuretic) — substances which are commonly used by anabolic steroid users. It is important, therefore, to exclude other possible causes of Tom's gynaecomastia (see further reading below).

The development of anabolic steroid-induced gynaecomastia commonly follows the following course: a skin ridge appears on the outer side of the areola (giving a halo appearance), with a concentric swelling which can be tender, followed by a build up of tissue resulting in the breast becoming more prominent.

Obviously this condition can be distressing for the patient, particularly for a young man who places much importance on his physique and appearance. It may also explain their temptation to search out another drug to combat the problem. However it is important to emphasise that for the majority of users who experience anabolic steroid-induced gynaecomastia, it will spontaneously resolve without recourse to medication (usually within a month or two), if it is identified and acted upon in its early stages — i.e. if the patient stops taking their current 'cycle' of drugs. While some anabolic steroid users have required surgery to correct gynaecomastia these are a small minority.

You should recommend that the patient should stop taking their current 'cycle' of anabolic steroids (and all other self-directed drugs). In the event of a patient having taken anabolic steroids at very high levels for many years, discussions regarding this process may be required. However for your patient, who appears to be a relatively new user, he should simply stop taking this 'cycle' of drugs. Obviously, some patients may be reluctant to follow this advice, but whilst you may wish to use this opportunity to discuss other risks associated with these drugs, it should be made clear that you are recommending that he stop taking his current 'cycle' to allow his current problem of gynaecomastia to resolve. If he chooses to commence a new 'cycle' of anabolic steroids in the future this remains his choice, however he must consider the lessons learned from this 'cycle' — i.e. whatever regimen of drugs he was using was likely to be too high and resulted in the gynaecomastia. He should be able to achieve the muscular gains he requires, and reduce the chances of adverse effects, using a much lower dose of anabolic steroids.

The drug to prevent or treat gynaecomastia that Tom refers to is likely to be the oestrogen-receptor antagonist tamoxifen (Nolvadex-D®). Clinically this drug is used to treat oestrogen-receptor-positive breast cancer and anovulatory infertility in women. There is widespread self-directed use of tamoxifen amongst anabolic steroid users with the aim of preventing and treating gynaecomastia, based on its 'anti-oestrogenic effects'. However, is also important to recognise that tamoxifen is in fact a Selective Estrogen Receptor Antagonist (SERM), and whilst acting as an antagonist in some tissues (notably the breast), it can act as an agonist in others. Ultimately we don't know what the short-term or long-term effects of disrupting the oestrogen signalling pathways will be in males.

Whilst there have been few controlled clinical trials on the use of tamoxifen for gynaecomastia, the drug is not approved for its treatment. Furthermore, where the cause is drug-induced (as is likely in this case), regression of the breast enlargement is likely to occur when the individual stops taking the offending drug.

Whilst recommending the patient stop taking his current 'cycle' of anabolic steroids — if only until the current problem has resolved — rather than suggest (or prescribe) an additional drug to go with his anabolic steroid 'stack', may not be the ideal outcome from Tom's perspective, it hopefully will result in honest and meaningful communication between you.

Further reading:

Braunstein GD. Clinical practice. Gynecomastia. N Engl J Med. 2007;357(12):1229-1237. http://content.nejm.org/cgi/content/full/357/12/1229

Niewoehner CB, Schorer AE. Gynaecomastia and breast cancer in men. BMJ. 2008;336(7646):709-713. http://www.bmj.com/cgi/content/full/336/7646/709

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Tuesday 23rd June 2009 Southwark Cathedral, London
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Please contact Lorna Boothe,the Part 1 Coordinator (**lboothe@rcgp.org.uk**) to enquire or book places on Part 1 Courses

Resolve: Motivational Interviewing Skills Training
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Date: Monday 28 - Tuesday 29 September 2009
Date: Monday 23 - Tuesday 24 November 2009
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